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The Special Counsel

December 15, 2022

The President
The White House
Washington, DC 20500

Subject: OSC File No. DI-19-1176

Dear Mr. President:

I am forwarding to you a report transmitted to the U.S. Office of Special Counsel (OSC) by the U.S. Department of Veterans Affairs (VA) in response to the Special Counsel's referral of disclosures of wrongdoing at the VA Southern Nevada Healthcare System (VASNHS) in Las Vegas, Nevada. The whistleblower, [redacted]—who was a pharmacist with VASNHS, and who consented to the release of [redacted] name—disclosed significant issues with VASNHS's mail order prescription system. I have reviewed the disclosure, agency report, and the whistleblower's comments, and in accordance with 5 U.S.C. § 1213(e), have determined that the report contains the information required by statute and the findings appear reasonable. The following is a summary of those findings and comments.[1]

The whistleblower disclosed that VASNHS's mail order prescription system[2] is grossly mismanaged, resulting in a gross waste of funds and a delay in patients' access to medications. Specifically, from at least 2016 to 2019, VASNHS destroyed thousands of dollars' worth of returned drugs each week because prescriptions were often mailed to incorrect addresses, and this destruction also resulted in the additional cost of replacement medications and postage. The whistleblower further alleged that VASNHS's mailing process caused a delay in patients' access to prescription medications that may have caused negative health ramifications for some patients.

The agency substantiated the whistleblower's allegations that VASNHS's mail order prescription system wasted government resources and delayed patients' access to medications. The report explains that VASNHS's mail order prescription system required signatures for all schedule II narcotics on delivery, contrary to Veterans Health Administration (VHA) Directive 1108.01—which resulted in increased mailing costs and delays in the delivery of controlled

[1] The allegations were referred to former VA Secretary Robert Wilkie for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The investigation was conducted by the VA's Office of the Medical Inspector, under the direction of the Executive in Charge, Office of the Under Secretary for Health.

[2] VASNHS uses the Consolidated Mail Outpatient Pharmacy (CMOP) system to provide mail order prescriptions. Prescriptions are mailed from three locations, all with a return address of the Las Vegas VASNHS pharmacy. The CMOP in Tucson, Arizona supplies medications for non-controlled medication refills, while the CMOP in Murfreesboro, Tennessee provides schedule III-V narcotics. Schedule II narcotics and high-value medications are mailed directly from the Las Vegas VASNHS pharmacy.

substances when patients were not home to sign for the medications.[3] The investigation identified one veteran who may have experienced a worsening of his or her condition due to the delays and identified two others who raised concerns of a possible worsening of their medical condition. Relatedly, the investigation found that no clear mechanism existed to notify the provider that a patient had failed to receive prescribed medications.

The report further explains that the returned prescriptions resulted in the destruction of approximately $100,000 worth of prescription medications from 2016 to 2019. Additionally, the report explains that due to VASNHS's signature requirement for all schedule II narcotics on delivery, the Las Vegas pharmacy spent approximately $10.00 more per package in postage costs—totaling more than $45,000 in excess postage costs.

The investigation identified other problems with the way returned medications were processed. For example, returned medications were logged on spreadsheets located on a shared drive for the pharmacy that were not password protected or secured, meaning the spreadsheets could be edited or modified by anyone with access to the shared drive. This was particularly problematic because the spreadsheets typically were the only record of the returned medications until they were entered in a more formalized report and verified by two pharmacists, which often took about five business days. The investigation also found that schedule II and high value medications mailed directly from the Las Vegas pharmacy were packaged in different packaging than that used by the other CMOP locations, violating VHA Directive 1108.1 and increasing the chances of narcotic diversion.

In response to the investigative findings, the agency implemented updated standard operating procedures (SOPs) to comply with VHA Directive 1108.1—including, no longer requiring a signature upon delivery of controlled substances. Additionally, VASNHS pharmacy management conducted a review of ongoing competencies for all pharmacy staff to ensure understanding and compliance with the updated procedures. And to avoid the opportunity for narcotic diversion and accurately account for returned prescriptions, VASNHS staff, the Murfreesboro CMOP, and the Tucson CMOP now use standard, unmarked packaging. VASNHS also developed and implemented a new 1108.1-compliant process to log returned medications that restricts access to the log. Lastly, VASNHS's Deputy Chief of Staff performed clinical quality reviews for the three patients identified as possibly suffering a worsening of their medical condition due to VASNHS's prescription mailing procedures and identified no adverse issues warranting further review. Yet, to avoid any potential harm resulting from non-receipt of mailed prescriptions, VASNHS updated its SOPs to require pharmacists to enter a note in the electronic medical record indicating a medication was unable to be delivered to a patient and providing notification to the ordering provider.

The whistleblower's comments focused primarily on the VA's decision to close neighborhood pharmacies and consolidate pharmacy services within VASHNS's medical center, which was not the subject of the referred allegations. The whistleblower also commented that the report fails to account for the cost of partial refills incurred by veterans who sought bridge prescriptions when their mailed prescriptions did not arrive in time, and it does not account for

[3] VHA Directive 1108.1 does not require a signature upon delivery. Signature on delivery is suggested only in limited situations, such as for patients with an identified trend of claiming non-receipt.

the cost of pharmacy staff time spent processing returned medications. The whistleblower further stated that the mail system generally presents a substantial and specific danger to public health or safety.

I commend the whistleblower for bringing these important issues to OSC's attention. I applaud the VA for addressing these issues and taking steps to ensure that VASNHS's mail order prescription system timely and efficiently delivers prescriptions to our Veterans.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter, the agency report, and the whistleblower's comments to the Chairs and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of these documents and a redacted copy of the referral letter in our public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures